

for tumor. He related a case in illustration of one advantage of the hypogastric method, in which perineal section for recurrent calculus was followed permanently by ejaculation of semen into the bladder. He referred to the popularity of litholapaxy in Boston, and emphasized the necessity of removing the debris in this operation.

T. R. VARICK, M.D., (Jersey City), thought the size of the stone had been made too much of a bugbear in perineal extraction, and presented a stone, weighing 7 ounces and 4 scruples, removed by the bilateral method from a boy of 14, without perceptible laceration; he also referred to the use of hot water as a styptic and aseptic.

D. W. YANDELL, M.D., (Louisville) had performed 92 operations by the perincum, 8 by lithotripsy and 6 by litholapaxy; he had seen two suprapubic operations but could as yet see no advantages in that method over the old ones. There were 7 deaths after his lithotomies and no recurrences, after the lithotrities there were 2 recurrences and 2 after the litholapaxies.

J. B. ROBERTS, M.D., (Philadelphia), could not change the opinion expressed by him three years previously that the high operation was destined to become an important one; it is safer for the inexperienced surgeon and better for exploratory purposes and the removal of tumors. He thought it however a rather severe method of treating retention from stricture, in which aspiration will generally on the second or third day at least, permit the passage of an instrument through the urethra.

J. E. MICHAEL, M.D., (Baltimore), had had considerable experience in the treatment of retention from stricture or prostatic disease, and had found suprapubic aspiration all that was necessary and with proper precautions safe. For exploratory purposes and in some cases for foreign bodies, there is no question of the propriety of the high operation, but for most cases of stone and for prostatic trouble, perineal section is preferable.—*American Surgical Association, 1887.*

JAMES E. ITLCHER (U. S. Army).

BONES, JOINTS, ORTHOPÆDIC.

I. Dislocation of the Hip. By HENRY MORRIS, F. R. C. S.

(London). This article was written in consequence of a lecture delivered by Prof. Humphry in which he used the following words: "It has lately been maintained, on insufficient grounds, I think, that dislocations of the hip backwards are always, or almost always, indirect; that the head of the bone escapes from the acetabulum close to the transverse ligament, and is then, if the limb be in an inverted position, carried backwards, and perhaps upwards. Furthermore, it is held that the accident occurs during the abducted position of the limb." Mr. Morris some years ago paid especial attention to this point, both by actual experiments and dissections on the cadaver, as well as by examination of museum specimens. He also was fortunate enough to see several cases in actual practice. From these he came to the conclusion that: (1). In the regular backward dislocations (*i. e.*, dorsal and sciatic) the head of the femur leaves the acetabulum in a downward or downward and backward direction through a rupture in the thin part of the capsule, and is carried upwards to its position on the dorsum illi or ischium. In other words, that these dislocations (when not complicated by fracture of one or both bones of the joint) are indirect in the sense that the head of the femur ascends to its position after having burst through the capsule at a lower point. (2). The thin part of the capsule is all that portion of it, except the narrow pubo-femoral band which is below and between two imaginary lines—namely, one drawn from the inferior iliac spine to the small trochanter, and the other from the upper part of the tuber ischii to the digital fossa of the femur. (3). During abduction the head of the bone bulges against the thin portion of the capsule, and that in this position dislocation most easily occurs. The mode of occurrence of backward dislocations described in No. 1 affords the only rational explanation of the ease with which dorsal and sciatic dislocations are reduced, or converted into the pubic variety, by manipulation. Prof. Humphry drew attention especially to the following points: (1). The position of the rent in the capsule by which the head of the bone escapes from the acetabulum—namely, at the lower and back part, behind the pubo-femoral ligament, therefore not at the lowest part, although the weakness of the capsule here may seem to predispose it to give way in this situation. (2). That dislo-

tion occurs commonly, and not as recently suggested, when the limb is abducted, but when the thigh is adducted, flexed and inverted. (3). That the dislocation is not indirect, but direct, the head of the bone being driven through the capsule at the lower and back part of the joint, and then carried up to a variable extent by the force which caused the dislocation. Mr. Morris agrees with the first and third conclusions if the word "indirect" and "direct" be transposed in the third. He quite denies the second conclusion. Prof. Humphry says that the probabilities are, of course, that the limb will be in an habitual or natural position when an accident occurs, and the position of flexion, abduction, and inversion, is both an habitual position and is one in which the head of the bone is pressed against the part of the capsule (the under and back part)." Mr. Morris contends that abduction is a usual and natural position, and also that in that position the head of the femur is pressed against the thin part of the capsule. Mr. Morris cites cases in which the accident did occur during abduction of the limb. He finally points out how the recognition of the fact that the injury which dislocates the femur onto the dorsum ilii acts indirectly on the bone influences our employment of manipulation in its reduction to the exclusion of the old method of reduction by direct means, viz., the use of pulleys.

H. H. TAYLOR (London).

II. A New Method of Immediate Retention in Fractures of the Tubular Bones. By DR. H. BIRCHER (Bern). Despite our very complete methods of treating fractures there are cases that resist every effort, and even though reduction is accomplished it cannot be retained either by dressings or weights. This is especially the case where the soft parts are not in condition to bear the pressure of a dressing or there is no suitable chance to apply extension. Here direct instead of mediate retention must be practiced. Various methods of achieving this have been used: Malgaigne's hook's, Dieffenbach's metal plugs with circumvolute suture, screws, bone suture, etc. Such methods have, however, rarely been applied to fresh fractures. Within a few years B. has treated a number of fractures of the lower extremity after another plan. This consists in the introduction of ivory